SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Authorization to Release Health Information

Return address

1. I request _____ to complete this form for me. _____
   (Person's name that completes the form) *(Signature of patient/personal representative)*
2. I _____authorize DPH to allow _____ to accompany me during my appointment on _____, and I understand that protected health information may be discussed during this appointment.
3. I _____authorize _____to disclose the following protected health information from the medical records of _____ _____ to_____.
   Name of Patient *Date of Birth*

Patient Initials All That Apply. (Checking "ALL" under a services type includes labs results for that service type.)

Service Type	Initials	All	Specific	Service Type	Initials	All	Specific
Alcohol/Other Substance Abuse				Mental Health			
CYSHCN				Newborn Home Visit			
Family Planning				Nurse Family Partnership			
HIV/AIDS				STD			
Home Health				TB			
Immunizations				WIC			
Lab/Diagnostic Tests				Other			

I do NOT want the following information released:
_____/_____. (Patient's initials)

4. Purpose for the release of information: (Patient initials **one**) _____continuation of treatment; or _____ personal copy; or_____ legal; or Other (Enter purpose for release and initial)_____
5. This authorization is effective until: (Patient initials **one**) _____One year from today; or _____ Until discharged from Program; or Other (Patient enters specific date or event and initials)_____
   I understand that a copy of this authorization may be treated as an original.
6. You may release my protected health information to the person or entity named in #3 above in the following ways:
   a) By fax _____(Patient initials here) Fax number _____
   b) By e-mail _____(Patient initials here) E-mail address _____
   c) By mail_____(Patient initials here) Mailing Address_____.
   I understand that my confidentiality cannot be guaranteed by sending my information by these methods.
7. _____ _____ _____ _____
   Signature of Patient or Personal Representative Date Witness - **ONLY** if patient cannot sign or signs with an "X" Date

   _____ _____
   (Printed Name of Patient) Relationship of Personal Representative (if signed by personal representative)

I understand that I may ask to see or receive a copy of my information before it is released. I understand that the information disclosed at my request may be re-disclosed by the person that receives it and may no longer be protected by state or federal law. I understand that DPH may not condition treatment, enrollment or eligibility for benefits if I refuse to sign this authorization; however, I understand that I may not be eligible for services from some programs if I refuse to allow the release of information needed for treatment, payment, enrollment or eligibility for benefits.

Copy of this form Provided to Patient ☐ **or Copy Declined** ☐ **or Copy Mailed to Patient** ☐

8. Revoking This Authorization: I understand that I may revoke this authorization at any time by signing below, except when information has already been released in reliance on this authorization or to obtain insurance benefits.

   _____(Patient/authorized representative) Date:_____
   _____(Witness: Required if patient cannot sign or signs with "x") Date:_____

(Patient label may be used here)

Patient's Name: _____
Date of Birth: _____

Information Released to:	**Information Released/Signature/Date:**
1. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	1. _____
2. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	2. _____
3. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	3. _____
4. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	4. _____
5. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	5. _____
6. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	6. _____
7. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	7. _____
8. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	8. _____
9. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	9. _____
10. Name: _____ Address: _____ City/State/Zip Code: _____ Other: _____	10. _____

(Patient label may be used here)

Patient's Health Record Number: _____
Patient's Name: _____
Date of Birth: _____

Instructions for Completing Authorization to Release Health Information
1623-ENG-DPH

Purpose: This form is used to obtain authorization from the patient, parent or legal guardian to release health information from one entity to another. (from DPH to another entity or from another entity to DPH). Another entity can require that we use their authorization form for release of information from their records.

Note: Secondary information (information not created by DPH that is filed in our records) will be released if the patient asks us to release it or if it is needed for continuation of care for the patient. If the secondary information is marked "not for re-release", it must be released from the entity that created it, not from DPH.

Item by Item Instructions:

1. If the patient requests assistance with the completion of this form, enter the name of the person assisting, and the patient signs here.

2. a) Enter name of the patient requesting to be accompanied during DPH visit.
   b) Enter name of individual accompanying patient.
   c) Enter the date of the visit. If this is all the patient is requesting, then move on to number 7.

3. a) Enter the name of the individual authorizing release of health information. (patient, parent or legal guardian)
   b) Enter the entity releasing information (if DPH is releasing information, enter DPH. If another entity is using this form to release their information to DPH, the name of that entity would be entered here.)
   c) Enter the name of the patient whose health information is being released. If this is the same as the name entered in 3a) above, "myself" may be entered instead of re-entering the name.
   d) Enter the entity the records are being released to (if DPH is releasing the information, enter the name of the entity DPH is releasing information to. If another entity is using this form to release health information from their records to DPH, enter DPH.)
   e) The patient initials the box next to the records to be released. Checking "all" records for a program area includes labs for that program area. If only part of the record for a program area is to be released, list the sections of the record to be released and have the patient initial. **Family Planning records of minors must not be released without the minor's authorization, unless a valid court order is received.** HIV or STD information cannot be released without patient initialing that program area and checking "all" records or providing details under "specific" column.
   If this release is being used to send health information to more than one entity (when allowed), enter "see reverse side of this form # **1**-# **X**". (e.g. if the information is being mailed to 3 different entities, enter "see reverse side of this form #1-#3".) **The information being released and the purpose for the release must be the same for each entity or separate authorizations must be completed for each of the entities.**
   f) If the patient does not want certain information to be released, he/she can specify that here and initial.
   g) If the authorization is requesting release of "psychotherapy notes", it may not be combined with any other authorization to release health information. (authorizations to release psychotherapy notes must be separate from all others.)

4. Purpose for release of information- the patient initials the purpose for the release of health information. (for continued treatment, for billing, for a personal copy, etc.) Enter ONLY ONE purpose per form.

5. Authorization is in effect until- enter a specific date or specific event when the patient wants the authorization to expire. (an example of an event would be "until discharged from the program") If a **date** is entered, the date **must not exceed one year.** If an **event** is entered, this **can exceed one year.**

6. Releasing PHI.
   a) the patient initials here to authorize DPH to fax PHI to the entity named on this form. Enter fax number, if known.
   b) the patient initials here to authorize DPH to use email communication. Enter email address, if known.
   c) the patient initials here to authorize DPH to mail PHI to entity named on this form. Enter the mailing address.

7. Signature/Date: The patient, legal guardian or personal representative signs here and enters the date the form is completed.
   Witness/Date: a witness signs and dates here **ONLY if the patient/personal representative cannot sign or signs with an "X".** Printed name: print the name of the patient/personal representative who signs the form.
   Relationship of Personal Representative: if someone other than the patient signs the form, enter that person's relationship to the patient.
   The patient will be offered a copy of the completed 1623-ENG-DPH. If a copy is provided to the patient, the DPH staff member checks that a copy was provided. If a copy was declined by the patient, the DPH staff member checks that a copy was declined. If the patient requests a copy be mailed to him/her, the DPH staff member checks that a copy was mailed, and then mails a copy to the patient.

HIPAA requires that we allow the patient the opportunity to request to inspect or obtain a copy of his/her protected health information prior to its disclosure. HIPAA requires that we inform the patient that once we release information to another entity, it may be re-disclosed by the recipient and may no longer be protected by state or federal law. (the entity receiving the information may not be "covered" by HIPAA and therefore, would not be covered by HIPAA privacy laws.)

HIPAA requires that we inform the patient that if they refuse to sign the authorization to release information, we cannot deny treatment, payment, enrollment or eligibility for benefits; and this will not prevent us from providing treatment to the patient nor from collecting payment for services rendered. The name of the entity releasing records is entered in the first blank. Some DPH programs require us to release information needed for treatment, payment, enrollment or eligibility for benefits prior to enrolling a patient into the program. In those instances, enter the program name here.

8. Revoking this authorization- if the patient wishes to revoke this authorization, he/she may do so at any time by signing and dating **the original authorization** here. The authorization is revoked on the date signed by the patient. A witness' signature is required **ONLY if the patient cannot sign or signs with an "X"**. The date the witness signs is entered here.

9. The patient's health record number, name and date of birth are entered in the bottom right corner. The patient label may be used instead, if preferred.

PAGE TWO of the Form:

1. In the first column, enter the name/address/city/state/zip code the information is mailed to. If other information is needed, enter that beside "other". If it is a release to a single entity and the information is provided on the first page, then DPH staff member can refer to that information instead of re-entering.

2. In the second column, enter the information that is released, the signature of the person releasing the information and the date the information is released

Office Mechanics and Filing:
This form should be filed in the comprehensive health record according to the Health Record Format located in the Health Record Policy Manual. The comprehensive health record retention schedule applies.

If there are questions as to how to complete or use this form, please contact the DPH Privacy Officer or the DPH Legal Office.